

## WISCONSIN MEDICAID OTHER COVERAGE DISCREPANCY REPORT

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement.

The use of this form is voluntary; providers may develop their own form as long as it includes all the information on this form. Attach additional pages if more space is needed.

**INSTRUCTIONS:** Use this form to notify Wisconsin Medicaid of discrepancies between other health care coverage information obtained through the Eligibility Verification System and information received from another source. Always complete Sections I and IV. Complete Sections II and/or III as appropriate. Wisconsin Medicaid will verify the information provided and update the recipient's file (if applicable). Attach photocopies of current insurance cards along with any available documentation, such as Explanation of Benefits reports and benefit coverage dates/denials. This will allow records to be updated more quickly. Type or print clearly.

### SECTION I $\frac{3}{4}$ PROVIDER AND RECIPIENT INFORMATION

Name — Provider (Last, First, Middle Initial)	Wisconsin Medicaid Provider Number	
Name — Recipient (Last, First, Middle Initial)	Date of Birth — Recipient	Recipient Medicaid Identification Number

### SECTION II $\frac{3}{4}$ MEDICARE PART A AND B COVERAGE

Medicare / HIC Number			
<input type="checkbox"/> Add		<input type="checkbox"/> Remove	
<input type="checkbox"/> Part A Coverage	Start Date	<input type="checkbox"/> Part A Coverage	End Date
<input type="checkbox"/> Part B Coverage	Start Date	<input type="checkbox"/> Part B Coverage	End Date

### SECTION III $\frac{3}{4}$ COMMERCIAL INSURANCE, MEDICARE SUPPLEMENTAL, AND MEDICARE MANAGED CARE COVERAGE

<input type="checkbox"/> Add	<input type="checkbox"/> HMO	<input type="checkbox"/> Medicare Managed Care
<input type="checkbox"/> Remove	<input type="checkbox"/> Medicare Supplement	<input type="checkbox"/> Other
Name — Insurance Company		
Address — Insurance Company (Street, City, State, Zip Code)		
Name — Policyholder (Last, First, Middle Initial)		Social Security Number — Policyholder
Policy Number	Coverage Start Date	Coverage End Date
Recipient Left HMO Service Area <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Recipient Left HMO Service Area (If Applicable)

### SECTION IV $\frac{3}{4}$ REPORT INFORMATION

Name — Individual Completing This Report		Date Signed	Telephone Number / Extension
Name — Source of Information Included on This Report			Telephone Number / Extension
Mail to Wisconsin Medicaid Coordination of Benefits 6406 Bridge Rd Madison WI 53784-6220	Fax to Coordination of Benefits (608) 221-4567	Comments	

(Attach additional pages if necessary.)